1 Introduction

This book's primary intended audience is helping professionals whose responsibilities bring them into contact with people who have drinking problems. We hope that generalists will find it a helpful introduction to the field and that generalists and specialists from all backgrounds will use it to enhance their diagnostic and therapeutic skills. Some individuals who themselves have drinking problems or love someone who does may also find the book valuable as an aid to understanding and coping with their situation.

Drinking problems occur across all social structures and cannot be neatly confined to the specialist addiction treatment sector. The text therefore considers the treatment of drinking problems across a range of approaches from informal, through nonspecialist, to specialist treatment. Because varied helping professionals will encounter drinking problems in their work, we have employed the generic word "clinician" to describe the person doing the helping and hope that the text is equally relevant to the needs of general medical practitioners, psychiatrists, and other medical specialists, nurses, psychotherapists, pastoral counselors, psychologists, social workers, and occupational therapists, among others.

The generic terms "drinking problems" and its close cousin "problem drinking" are employed throughout the book to encompass a diverse range of difficulties that range from what is popularly described as "alcoholism" to far less severe cases that nonetheless would benefit from intervention. Indeed, a key message of the book is that there is no one sort of drinking problem and that interventions should be tailored to the realities of the patient's situation rather than being applied in a one-size-fits-all fashion.

The book is divided into two sections. The first provides essential context for understanding drinking problems and their effects, whereas the second digs into the specifics of treatment. The content of each chapter is synopsized here.

Part I: Background to understanding (Chapters 1–7)

Definitions of drinking problems (Chapter 1)

This chapter opens with a number of vignettes describing the many faces of drinking problems, and this is followed by an account of "sensible" drinking guidelines. Three categories of alcohol misuse are defined: hazardous drinking, harmful drinking, and alcohol dependence. The clinical genesis of the concept of the alcohol dependence syndrome is outlined, the individual elements of the syndrome are discussed, and the relevance of an understanding of dependence to the specifics of treatment is considered.

Alcohol as a drug (Chapter 2)

Alcohol is a drug that has important pharmacological and toxic effects on most systems in the human body. Knowledge of these pharmacological effects is basic to understanding the problems that arise from its use as well as the treatment adopted. The language in this chapter is necessarily technical, but we have tried to write the text in a way that is accessible to the nonmedical reader.

Causes of drinking problems (Chapter 3)

This chapter endeavors to explain why some people and not others develop drinking problems. Environmental factors, such as alcohol availability and cultural norms, are addressed, as well as economic factors, biological predisposition, and psychological mechanisms.

Alcohol-related problems (Chapters 4–7)

Chapter 4 through 7 deal with the complications of alcohol problems, which encompass a number of domains: social (Chapter 4), physical (Chapter 5), psychiatric (Chapter 6), and other drug problems (Chapter 7).

Part II: Treatment: Context and content (Chapters 8–17)

Introduction, settings, and roles (Chapter 8)

Only a small minority of people with drinking problems actually make contact with specialist services. This chapter thus takes a broader view of where problem drinkers may find help, exploring help-seeking trajectories that include informal, nonspecialist, and specialist treatment paths.

Case-finding and intervention in nonspecialty settings (Chapter 9)

Nonspecialist settings offer the opportunity to intervene earlier in the life course/drinking career, before problems become severe. Even a small intervention made early enough can have significant long-term impact. A number of nonspecialist settings are described, ranging from primary care to the workplace. We include general psychiatry services, where drinking problems are all too often overlooked despite the capacity to treat them. Case finding and detection are considered, and this is followed by a review of biological markers and screening questionnaires. Intervention within the nonspecialist setting is described, and a more detailed account of brief motivational interviewing and medical management is given.

Assessment (Chapter 10)

This chapter covers practical issues related to the art and technique of history-taking. Assessment of drinking as well as of other domains of a patient's life are addressed, as are ways to shorten assessment times when necessary. The role of assessment in guiding case formulation and treatment goal-setting is also discussed.

Withdrawal states and their clinical management (Chapter 11)

Detoxification is an important prelude to the further treatment of the dependent drinker. This chapter covers the medical and clinical basics of alcohol withdrawal, but also guides the

nonmedical reader through the underlying principles. The diversity of withdrawal states, the choice between community and in-patient settings, and the correct use of medication are all addressed.

The therapeutic relationship (Chapter 12)

This chapter emphasizes that the relationship between the clinician and problem drinker is as important as the treatment techniques or therapeutic tactics used. Likewise, changing behaviour is impossible without significant motivation on the part of the patient, and the nurturing of this motivation is core work for the clinician. Some guiding principles for working with the patient are given, and the question of when treatment ends is also reviewed.

Specialist treatment (Chapter 13)

This chapter reviews the evidence base for specialist treatments, with a particular focus on motivational interviewing and motivational enhancement therapy, cognitive behavioural therapy, and pharmacotherapy. The chapter places particular emphasis on the view that treatment should be research-based.

Alcoholics Anonymous and other mutual-help organizations (Chapter 14)

Alcoholics Anonymous (AA) is an international self-help organization that has helped countless millions of people with drinking problems since it was founded in 1935. This chapter provides an introduction to how AA operates and to its beliefs and practices. The importance of effective cooperation between treatment professionals and AA is emphasized. Alternative mutual-help organizations are also discussed.

Religion, spirituality, and values in treatment (Chapter 15)

Values, whether religiously derived or not, shape how people understand their drinking problem, their treatment, and their goals in life. Spiritual and religious issues are also commonly addressed in the treatment of drinking problems. This chapter explores the meaning of spirituality and religious belief, considers the spiritual "fallout" that occurs as a result of addiction, and tries to make sense of what all of this means when working with someone who has an alcohol problem.

Pursuing treatment outcomes other than abstinence (Chapter 16)

Not all people with drinking problems need to abstain in order to live healthy and productive lives. This chapter explains when a goal of moderate drinking may be more appropriate in treatment. It also discusses situations in which clinicians may decide that drinking-related treatment goals must be subordinated to other urgent clinical concerns.

Managing setbacks and challenges in treatment (Chapter 17)

This is a practical chapter that deals with common clinical situations in which treatment comes up against difficulties. It considers how such problems arise and how to reconfigure the therapeutic strategy in such situations in order to get on course again.

Part I

Background to understanding

Chapter 1

Definitions of drinking problems

The many faces of drinking problems

To many workers in the field, including readers of prior editions of this volume, the phrase "drinking problem" conjures up thoughts of cases like this one:

> Robert is a 45-year-old unemployed white man who was admitted to the in-patient alcohol unit for medically assisted withdrawal from alcohol for the second time in a year. He began drinking heavily in his teens. Since then, he has had only a few transitory periods of abstinence, all of them stimulated by short-term contacts with treatment professionals and mutual help groups. His wife became fed up with his drinking 5 years ago and kicked him out of the house. He has lived since in shelters, halfway houses, single-room occupancy hotels, and other marginal housing arrangements, including periods when he slept under a bridge with his "bottle gang." In morning group on the ward, his hands shake as he holds his cup of tea and tells his doctor and fellow patients in a trembling voice that "this time, I'm really going to make a go of it."

Individuals with severe alcohol dependence seen in specialist care settings, such as Robert, are familiar to anyone who works in the alcohol field and remain one focus of this edition of this book. Yet drinking problems occur and present across all social structures and health resources and are not neatly confined within the specialist addiction sector. This text, professing to address the treatment of all sorts of drinking problems, considers the whole range of approaches from informal through nonspecialist to specialist services. As such, it does not merely comment on the treatment of established alcohol dependence but also examines preventive factors that reduce the population prevalence of drinking problems and the clinical interventions that can benefit individuals with less severe alcohol problems. Cases as diverse as the following are thus within the ambit of this volume:

> Michael is a 50-year-old successful salesman of Indian descent. He is slightly overweight and is being monitored regularly by his primary care physician for elevated blood pressure. His doctor is mystified by the difficulty they experience in bringing Michael's blood pressure under control; the medications and diet recommendations do not seem to be working. During an early afternoon appointment, the doctor notices that Michael seems slightly tipsy and asks if he has been drinking. Michael smiles and says: "A three martini lunch with clients is standard practice in the sales game. But it's not like I'm an alcoholic or anything: I've got a house, a great family and I'm a star performer at my firm. So, on the blood pressure, are you going to switch my medication or what?"

> Emily is a 22-year-old honours college student whose roommate brings her to the Emergency Room[1] at midnight on a Saturday for treatment of facial bruising and a cracked

tooth. Emily had been assaulted by her boyfriend who was convinced that she had been flirting with the barman. Emily's boyfriend goes on pub crawls many times during the week; she accompanies him only on weekends. Her boyfriend is under arrest and Emily is sobbing hysterically that she doesn't want him in jail. With slurred words, she protests: "He's not really like that – it's the drink that makes him act that way. I've been after him to cut back." Emily attempts to leave as soon as her injuries are treated, but the doctor asks her to wait a moment so that the alcohol liaison nurse can have a word with her. "About my boyfriend's drinking?" Emily asks. "No," says the doctor kindly, "about yours."

George was a "workaholic," well-respected judge until the age of 65. During his retirement, he began for the first time in his life to experience long periods of boredom, which led him to spend inordinate amounts of time practising his hobby of wine tasting. After a particularly indulgent weekend, he experienced an episode of loss of consciousness, bit his tongue, and was incontinent of urine. Believing that George had suffered a stroke, his wife telephoned an ambulance that took him to hospital. He was admitted to the clinical decision unit overnight, and, the next day, transferred to a neurology ward for further investigation. Two days later, he started to become confused and suspicious, and, during an MRI scan, leaped off the trolley, pulling out his intravenous line. "That machine is trying to read my mind!" he yelled, maintaining that the stolen personal information would be used by the criminal fraternity to destroy his family in a final act of revenge. He was restrained by the hospital security team, and, following a short period of sedation with benzodiazepines, he recovered but still finds it difficult to understand this frightening period in his life.

A population perspective on drinking

Drinking within a population can be envisaged as a continuous spectrum ranging from nondrinkers, through "moderate" or "low-risk" drinkers, to individuals like those described in the preceding examples who have drinking problems of varying severities. Across populations, the proportion of people who fall into these categories ranges widely, for reasons explored in Chapter 3.

Defining drinks and low-risk drinking

A precondition for defining how much drinking is unhealthy is standardizing the term "drink." Standard drinks vary across different countries, and this must be taken into account when reading the literature or using instruments that quantify drinking behaviour (see Table 1.1). Many countries use the World Health Organization (WHO) standard of 10 g of pure alcohol, roughly equal to that found in a 100 mL glass of wine. In contrast, in the UK, a "unit of alcohol" is 8 g, roughly the amount contained in an Imperial Measure of a half-pint (284 mL). In the United States, product sizes are typically set in ounces, and a standard drink is 14 g, which is roughly equal to the alcohol contained in a 12-ounce can of beer.

In the UK, the drinking guidelines formulated by the Royal Colleges of Physicians, Psychiatrists and General Practitioners converged in the mid-1980s to define low-risk drinking as being less than 21 units of alcohol per week for men and less than 14 units per week for women (British Medical Association, 1995). Consumption of 22–50 units per week for men and 15–35 units per week for women was considered as hazardous and the consumption of more than 50 units per week for men and 35 units per week for women as harmful. In 1995, the Department of Health moved from weekly to daily limits and advised that "regular consumption of between 3 and 4 units a day by men of all ages will not accrue

Table 1.1. Example of standard drink sizes in different countries

Country	Standard drink (grams of ethanol)
Australia	10
Bulgaria	13
Canada	13.6
France	10
Ireland	10
Luxembourg	12.8
Mexico	14
UK	8
USA	14

Source: Kalinowski & Humphreys, in press

Table 1.2. Examples of recommended daily drinking limits in different countries (grams of ethanol)

Country	Men	Women
Australia	20	20
Canada	40.7	27
Japan	40	20
The Philippines	28	14
USA	28/56	14/42

Source: Kalinowski & Humphreys, in press

significant health risk" (Department of Health, 1995, p. 32). Likewise, women were advised that "regular consumption of between 2 and 3 units a day by women of all ages will not accrue any significant health risk" (Department of Health, 1995, p. 32). These guidelines, based on epidemiological data of alcohol-related morbidity and mortality, were similar to those available in many other countries (see Table 1.2). However in 2016, the UK Chief Medical Officers amended their advice based on the latest evidence about the impact of alcohol consumption on health, notably cancer (Dept of Health, 2016). They recommended to *both* men *and* women that "you are safest not to drink regularly more than 14 units of alcohol per week," "to spread this evenly over 3 days or more," and "adopting alcohol free days."

U.S. guidelines are based on 14 g units and somewhat confusingly define "moderate" and "low-risk" drinking differently. The former is up to one drink per day for women and two for men, whereas the latter is up to three standard drinks a day for women and four for men

(Kalinkowski & Humphreys, in press). Interestingly, not all guidelines around the world recommend lower drinking limits for women than men, despite evidence that women experience more health harm per unit of alcohol consumed than do men. For example, the Australian National Health and Research Council (2009) recommend for both men and women a limit of 20 g/d (two standard Australian drinks).

How much influence low-risk drinking guidelines have on alcohol consumption patterns is open to debate. Drinking above recommended levels is commonplace. Using data from the U.S. National Longitudinal Alcohol Epidemiologic Survey, Dawson and colleagues (Dawson, Archer, & Grant, 1996) calculated that a third of drinkers never exceed moderate alcohol consumption, a third do so occasionally, and for the rest it was their usual behaviour. Furthermore, 88 percent of the alcohol was consumed in a risky fashion. Similarly, in England, the General Lifestyle Survey reported that 39 percent of men and 28 percent of women had exceeded daily recommended limits on the days they drank the most alcohol (Lifestyle Statistics, Health and Social Care Information Centre, 2013). Notably, this was most common in the over-65 age group. In Australia, 24 percent of males and 17 percent of females reported drinking more than the recommended guidelines for acute harm on at least one occasion a month (Australian Institute of Health and Welfare, 2008), and 62 percent of the alcohol consumed was at a risky/high-risk level for acute harm (Chikritzhs et al., 2003). This percentage rose to more than 80 percent among the 14- to 17-year-old and 18- to 24-year-old age groups (Chikritzhs et al., 2003). Globally, alcohol contributes to about 4 percent of the burden of disease, with greater burden in higher income countries and in men (Rehm et al., 2009; World Health Organization, 2009).

Categories of high-risk drinking

Three categories of drinking outside of recommended limits make up the top three tiers of the pyramid in Figure 1.1: namely, hazardous drinking, harmful drinking, and alcohol dependence (Edwards, Arif, & Hodgson, 1981). *Hazardous drinking* refers to drinking that

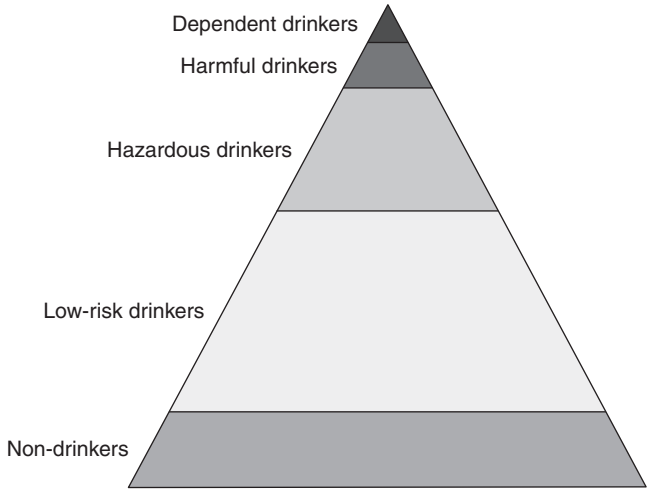

Figure 1.1: Drinking within the population. The areas are not accurate representations of the relative proportions of those exhibiting differing drinking behaviours because this varies among populations.

has not yet accrued any harm but exceeds safe limits. *Harmful drinking* describes drinking behaviour that has incurred damage. The division between these two is somewhat arbitrary because harms from drinking may go undetected (e.g., liver damage). The third category of high-risk drinking clusters with other problems (e.g., craving, blackouts) that together are suggestive of alcohol dependence.

Hazardous drinking

Hazardous drinking refers to drinking more than a certain limit that places the individual at risk of incurring harm (Edwards, Arif, & Hodgson, 1981). The WHO (1994) *Lexicon of Alcohol and Drug Terms* described hazardous use of a substance as:

> A pattern of substance use that increases the risk of harmful consequences for the user. Some would limit the consequences to physical and mental health (as in harmful use); some would also include social consequences. In contrast to harmful use, hazardous use refers to patterns of use that are of public health significance despite the absence of any current disorder in the individual user.

Hazardous drinking usually applies to anyone drinking more than the recommended levels. One common pattern of hazardous use is "binge drinking," a term and its synonyms (e.g., bout, bender, spree) used to describe drinking "a lot" in everyday speech. Clinical and scientific definitions vary nationally.

The U.S. National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines binge drinking as a pattern of drinking that brings blood alcohol concentration levels to 0.8 mg/dL, which typically occurs after four drinks for a woman or five drinks for a man, consumed over 2 hours or less. Binge drinking is not represented in Figure 1.1 or in the diagnostic criteria because it is not specific to any level of consumption: hazardous, harmful, and dependent drinkers may all engage in drinking binges.

Hazardous drinkers do not usually seek help for an alcohol problem. They are typically identified opportunistically in the primary care, general hospital, and other nonspecialty care settings (see Chapter 9).

Harmful drinking

Unlike hazardous drinking, harmful drinking is known to have damaged the drinker (Edwards, Arif, & Hodgson 1981). *Harmful psychoactive substance use* (in this case, alcohol) is a diagnostic term within the International Classification of Diseases (ICD-10):

> A pattern of psychoactive substance use that is causing damage to health. The damage may be physical (as in cases of hepatitis from the self-administration of injected drugs) or mental (e.g. depressive episodes secondary to heavy consumption of alcohol). (World Health Organization, 1992, pp. 74–75)

Although harmful use often has adverse social consequences, social consequences in themselves are not sufficient to justify a diagnosis of harmful use. The parallel diagnosis in the fourth iteration of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) was alcohol abuse: a "maladaptive pattern of alcohol use in the absence of a diagnosis of alcohol dependence" (American Psychiatric Association, 2000).

However, DSM-5 has replaced the diagnoses of alcohol abuse and alcohol dependence with alcohol use disorder (AUD). AUDs exist on a continuum, with mild, moderate, and

severe subclassifications. Although many criteria remain the same in DSM-5, legal consequences have been removed and the term "craving" added (American Psychiatric Association, 2013). Of the 11 criteria, 2–3 are required for a diagnosis of mild AUD, 4–5 of moderate, and 6 or more for a diagnosis of severe disorder (see Table 1.3). As a consequence of these changes in DSM-5, an individual could now meet criteria for having an AUD with a level of drinking that would not have met DSM-IV alcohol abuse criteria. ICD-11 is in development and appears likely to maintaining the ICD-10 categories of harmful use and dependence.

Alcohol dependence (syndrome)

The top of the pyramid in Figure 1.1 represents the dependent drinker. These individuals typically have a history of alcohol-related problems and constitute most of the caseload in specialty alcohol treatment services (although they also present elsewhere). Moderately dependent drinkers will show evidence of tolerance, alcohol withdrawal, and impaired control over drinking. Severely dependent drinkers typically have long-standing problems and a history of repeated treatment episodes.

Based somewhat on the traditions imposed by different diagnostic systems, some scientific and clinical work on this population of drinkers has been organized under the concept of "alcohol dependence" (e.g., studies using the DSM-IV), whereas other work has been informed by the concept of the "alcohol dependence syndrome" (e.g., studies using the ICD-10). Etymologically, the English word "syndrome" derives from the Greek *syn* meaning "together" and *dromos* meaning "running." Thus, the "alcohol dependence syndrome" as operationally defined by the ICD-10 is a collection of symptoms that "run together," including a compulsion to take alcohol, difficulty with control, withdrawal symptoms and relief drinking, tolerance, predominance, and persisting use despite evidence of harm (see Table 1.4). Nonetheless, the ICD-10 requires only three of the criteria to be present, and so perhaps the strict definition of syndrome as "consistently occurring together" should not apply to the ICD-10. Many people diagnosed as alcohol dependent under ICD-10 will meet the DSM-5 criteria for severe AUD, which are similar and include tolerance, withdrawal symptoms, taking of alcohol in greater amounts than intended, desire or unsuccessful attempts to cut down, spending extensive time in activities to obtain alcohol or recover from consuming it, giving up of activities, and persistent use despite associated problems (see Table 1.3).

Making the diagnosis of dependence should not be a mechanistic tick-box exercise. Dependence cannot be conceived as "not present" or "present," with the diagnostic task then completed. Clinicians must recognize the subtleties of symptomatology, which will reveal not only whether this condition is there at all but, if it exists, the degree of its development. What has also to be learnt is how the syndrome's manifestations are molded by personality, environmental influence, or cultural forces. The ability to comprehend variations on the theme constitutes the real art of clinical diagnosis. For instance, craving may have a different meaning to the clinician and the patient, and alcohol-related consequences may depend on context. If clinicians cannot recognize *degrees* of dependence (or severity of AUD), they will be unable to adapt their approach to the particular individual, and they may retreat into seeing "alcoholism" as a fixed entity from which all individuals with drinking problems are presumed to suffer, for whom the universal goal must be total abstinence, and with the treatment offered being universally intensive.